Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestors' Name and Address: Keith Heier, M.D. P. O. Box 118828 Carrollton, TX 75010	MDR Tracking No.: M4-04-4171-01 Claim No.: Injured Employee's Name: Date of Injury: Employer's Name: Insurance Carrier's No.:
Respondents' Name: Carrollton Farmers Branch ISD Box 43	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary:

The Requestor stated that, "...In reference to a copy of the authorization for this date of service please note that the authorization number on the claim was obtained from the facility that the patient was admitted to so our office does not have the actual paperwork for this authorization..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary:

The Respondent stated that, "The carriers' decision stands. The service date of 12/29/02 and 12/30/02 were never preauthorized. Carrier did waive the spinal surgery and received notice it was approved on 9/28/01 from the Division. The services rendered for this hospitalization is two months after the expiration of the one year deadline. Also, the carrier has no record of a hospital bill for this service. Provider states they have a preauth-the preauth number is the injured worker's social security number."

Principle Documentation: 1. DWC-60 Response/Position Summary
2. EOBs

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Payment Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12/29/02	A/240	99253 99233	1-6	$0.00
TOTAL DUE				$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

1. The disputed issue: Whether reimbursement is due the Requestor for inpatient consultation services under the 1996 MFG.

2. The Respondent's EOB denial code "A/240" asserts, "Preauthorization not obtained." Regarding the reconsideration request, the Respondent stated that, "The original review stands. These services appear to be integral to a service requiring pre-authorization per DWC §134.600. However, we have never received a correlating hospital bill."

3. Review of the file reveals that the Requestor billed the Respondent for CPT code 99253, which was rendered on 12/29/02.

4. According to the Table of Disputed Services, the Respondent was also billed for CPT code 99233, which was rendered on 12/29/02. However, review of the CMS-1500s does not indicate that the Requestor billed the Respondent for this code on 12/29/02. Therefore, a review of this code cannot be conducted.

5. Review of the file confirms that the preauthorization number provided by the Requestor is the injured worker's social security number.

6. Review of the file reveals that the Requestor did not provide documentation regarding the approval of the inpatient consultative services or the actual hospitalization itself. Since the Requestor has not provided documentation that preauthorization was approved prior to rendering the above services in accordance with §134.600, reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011 (a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.600

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.011, the Division has determined that the Requestor **is not** entitled to additional reimbursement.

Decision by:

Authorized Signature	Typed Name	Date of Decision
Regina Cleave	Regina Cleave	November 21, 2006

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.